1 March 2006

MEDICAL EDUCATION AND TRAINING CENTER WHITE PAPER

1. Purpose. The purpose of this paper is to identify issues impacting on structure and process for the Medical Education and Training Center (METC) recommended in the Base Realignment and Closure (BRAC) announcements in May 2005. For the purposes of this paper, organizational structure includes command and control, potential command and control structures, and other issues impacting on the composition of the organization. Also included are issues associated with Military Health System Roadmap Initiative # 5 (TO-5) entitled *Joint Medical Education and Training Focused on Performance-Based Management.* The tasking, dated 3 January 2006, is from the Military Health System Office of Transformation (MHS-OT) and makes the BRAC Medical Flag Officer Steering Committee (FOSC) the Office of Primary Responsibility (OPR) for building an implementation plan and participating in subsequent execution of the initiative.

2. Source and Applicability. This paper represents thoughts developed by the METC Executive Integrated Process Team (EIPT). The group consists of representatives from the Army, Navy, and Air Force and is charged with planning for implementation of TO-5 and the BRAC recommendation regarding consolidation of Service medical training. The contents of this paper lay out a series of concepts and issues which will impact planning and execution. These concepts and issues have been identified to the FOSC guiding BRAC implementation for the Service medical departments and serving as the OPR for TO-5. The METC end state and level of integration of the guidance in TO-5 are dependent on participation and approval from the Services, the Joint staff, and Combatant Commands (COCOMs).

3. Background. The BRAC recommendations released in May 2005 included a recommendation for re-locating basic and specialty enlisted medical training to Fort Sam Houston, Texas. The recommendation specifically called for co-location of training from the primary Air Force medical training unit, the 882D Training Group (882 TRG) at Sheppard Air Force Base, TX, and the Navy medical training centers at Great Lakes Naval Station, Portsmouth, VA; and San Diego, CA to Fort Sam Houston TX, with the potential of transitioning to a joint training effort. Follow up questions gave definition to the intent of the recommendation which included co-location of officer supplemental and medical readiness training where such action made sense. The BRAC legislation requires that the recommendations be executed within six years of the President signing of the bill into law. Addition of the requirements specified in TO-5 greatly expand the overall requirements by adding leadership, joint training, performance-based leadership training, and lifelong learning to the common curriculum, training commonality, and use of best practices identified by the Executive IPT for execution of the BRAC recommendations. Further discussion of the requirements and implications of TO-5 are included in Paragraph 10 below.

a. Shortly after announcement of the Department of Defense BRAC recommendations the Service medical departments began planning the actions necessary for implementation. Initial analysis of the student loads associated with the move showed that the average daily student load (ADSL) anticipated at the METC would approach 9,000 students in its end state versus the 6271 student man years used in the BRAC calculations.

b. The METC Executive IPT initiated its planning with the understanding that any implementation solution must, without question, include the capacity required to meet the force structure requirements of the Services. Without this as a baseline no solution can be successful. No issue, no

command or organizational structure will have meaning unless Service force structure requirements are met. Additionally, the IPT members agreed that the consolidation must be accomplished without degrading existing Service capabilities.

c. Current Command Structures. Currently the Services conduct medical training/education using different organizational and command structures.

(1) Army medical training is conducted and managed by the Army Medical Department Center and School (AMEDDC&S) at Fort Sam Houston, TX. The organization is a major subordinate command of the U.S. Army Medical Command (MEDCOM) which is commanded by the Army Surgeon General. The organization conducts/manages education and training for Army medical personnel with the exception of graduate medical education. Fort Sam Houston is the primary location for the training. Resources for the training come through medical command channels.

(2) Navy medical training is conducted under command of the Naval Medical Education and Training Command (NMETC) located at Bethesda, MD. Training is conducted at the Naval Hospital Corps School (NHCS), Great Lakes Naval Training Center, IL; the Naval School of Health Sciences (NSHS), Portsmouth, VA; and NSHS, San Diego, CA. The NMETC is a separate Navy command under the Bureau of Medicine and Surgery. Similar to the Army, resources for Navy medical training flow through medical command channels.

(3) Air Force pipeline and supplemental medical training is primarily conducted by the 882 Training Group (TRG) located at Sheppard Air Force Base, TX. The 882 TRG is a subordinate unit of the 82nd Training Wing and falls under 2nd Air Force, Keesler AFB, MS. These units are part of the Air Education and Training Command (AETC) headquartered at Randolph Air Force Base, TX. AETC is the primary command responsible for Air Force pipeline training, is a line command, and provides command and control for students. Resources to support the medical training follow mixed channels. The funding for instructional staff comes from the Defense Health Program (DHP) while student funding is primarily through AETC. Thus, a major component of the funding for medical training follows command channels and, unlike the Army and Navy, these are line command channels and not medical.

4. Assumptions.

a. Capacity requirements to execute the BRAC recommendation to consolidate medical training will be met.

b. Service specific training requirements will exist and must be accounted for in any solution used to build METC organization and processes.

c. Possibilities for formation of the METC may range from an organization that is purely joint to one that is purely staffed and managed by a single service. The possibility actually selected will have a tremendous impact on the organizational structure of the METC at end state.

d. Consolidation of training will achieve the best use of available resources and generate optimal efficiencies.

e. Training consolidation will be based on use of best education and training practices across the Services.

f. Accreditation of programs and the ability to grant degrees will be considered best practices and, therefore, goals of the METC end state.

5. Issues. Organizational structure is commonly recognized as a key element of success in large organizations. While it is not by any means the sole determining factor, a functional organizational structure that meets the needs of the operational entities contributing to mission accomplishment means that the organization is set up for success. A dysfunctional structure means that the organization is

predisposed to fail or to require excess energy or resources to overcome its shortcomings and achieve success. The organizational structure includes the command structure and the processes that support the organization's mission. Below is a discussion of some issues that will directly impact the organizational structure.

a. Command Environment. The environment in which the command operates will be a direct determinant of many of its processes and structural components. It will impact nearly every area of operations. Potential command environments for the METC are bounded by the purely joint at one end of the spectrum and the purely service-operated at the other. Options for the command environment include but are not limited to:

(1) Purely Joint. A truly joint environment will include an organizational structure in which the authorizing documents are validated with authorized joint billets for both staff and students. In this option command and staff positions would be open to individuals from any service, the expectation being that they would be filled on a "best qualified" basis from available resources across the Services. Policy would be needed to determine whether key positions, e.g., commander and other senior leader positions, would be filled from the Service medical departments on a rotating basis or whether "best available" at the time of the requirement would be acceptable. Staff positions throughout the organization could potentially be filled by personnel from any of the Services.

(2) Unified. A unified environment might consist of a structure in which a jointly staffed headquarters element is positioned to support subordinate service-specific elements. Staffing of headquarters elements, as well as teaching departments, would be jointly manned but the student structure would belong to the respective services. "Rotating" or "best qualified" determinations would be required to fill the key senior leader positions. Again policy, potentially in the form of a validated staffing document, would be required to determine which service would be responsible for filling positions throughout the jointly staffed components of the organization. Options for documenting Service positions in the headquarters element and teaching departments could range from a jointly staffed model in which any of the positions could be filled by qualified personnel from any Service to the United Nations staffing model in which specific functions, for example logistics, operations, or personnel management, are made the responsibility of a single nation or, in this case, of a single Service.

(3) Executive Agency. In this environment the primary responsibility for operation of the organization would be given to a specific Service. This does not mean that positions in the staffing model would not be filled by individuals from across the Services. It does, however, lend itself to filling key leader and management positions with individuals from the responsible Service. Likely service-designated positions would include the commander and resource manager positions since executive agency would align command responsibility and resource flow with the responsible service. Other senior leader, staff, and teaching department positions might well be staffed from across the Services. Again, policy determinations and inter-service agreements would drive the remaining structure. In an "executive agency" environment service-specific student structure similar to that in a unified environment is a likelihood.

(4) Pure Service. Although an option, a pure service environment in which a single service is given the responsibility to staff and provide medical training to meet the requirement for trained personnel across the Department of Defense is unlikely at best. It is presented here only as a placeholder at the opposite end of the spectrum from the purely joint environment. In this case the headquarters and teaching department staffs would be single service but responsible for meeting training requirements for all Services. Student leadership structure would again be service-specific.

(5) Hybrid. It is important to recognize that across the spectrum between pure joint and pure service environments the options are not necessarily limited to those presented in paragraphs (1) through (4) above. Numerous hybrid possibilities exist in varying degrees. The environmental options presented, however, do represent the most familiar and, therefore, the most likely potential solutions.

(6) Ongoing Studies. As of the date of this paper there is a Joint/Unified Command study ongoing in the Department of Defense (DOD) evaluating options for a joint or unified military medical command. There are several options under consideration and each incorporates structure for a Joint Medical Education and Training Command. Exactly where that command would fit in the structure and how it might function are yet to be determined. Both separate command and staff function under the J-7 are under consideration. A decision is expected in the summer '06 time frame; approval would greatly simplify the command environment questions impacting the METC.

b. Governance. The term governance is used in this document to represent two concepts, senior command and academic governance, both of which are key to the operational future of the METC.

(1) The reporting lines to a senior command established for the METC will likely derive from the designated command environment in which it is told to operate. The reporting lines for the commander of the METC will determine in large part how command and control, internal and external to the organization, function.

(a) As indicated in Paragraph a (6) above, potential structures for a joint or unified medical command are currently under study and consideration within the DOD. Existence of such a command would simplify the METC senior/subordinate command relationship. The command structures currently under study would have representation from and responsibility for medical support in all Services. Making the METC, also with tri service representation and responsibility, a subordinate element of that command would give the METC commander a direct line of command to include a direct line for reports and resource flow.

(b) Existing reporting lines for Service medical training organizations are different. Navy medical training schools report in a direct line to the NMETC. In a similar fashion, the AMEDDC&S, the Army's medical training school, is a direct major subordinate command of the MEDCOM. In the Air Force, however, the medical community acts in an advisory capacity rather than in a direct command line. Training in the Air Force, to include medical training, is under the purview of the AETC; as a result, the 882 TRG follows those command channels.

(c) There is an additional similarity between the Army and Air Force. While the Training and Doctrine Command (TRADOC) is not in a direct chain of command relationship to the AMEDDC&S the way AETC is to the 882 TRG, it still has significant impacts on Army medical training. TRADOC establishes training requirements, processes, and policy for the Army, all of which the AMEDDC&S is expected to follow. The NMETC has a relationship with the Naval Education and Training Command but it is a less formal relationship than that of the Air Force and Army medical training organizations with their Service training commands. Reconciling education and training policy issues of interest to all services will require significant effort as organizational and instructional process designs of the METC proceed.

(d) As progress toward formation of a METC proceeds, reconciling the interests of the various commands that presently control Service medical training may prove challenging because the issues involved include command and control of young recruits as well as significant personnel and fiscal resources. Since no joint or unified medical command currently exists and advent of the joint/unified command is not a surety, the METC must identify and be prepared to deal with the

complexities and interrelationships in a set of potential command relationships that is not straight forward.

(2) Academic governance is an issue that will drive certain components of the METC structure both internal to and outside the organization. A major component of the vision for the METC is that it will become a world class education and training institution in support of military medicine. To become that world class entity it will be necessary for the METC to have the capability to grant academic credit and degrees in response to successful completion of courses of study and maintain the capability to provide lifelong learning modules to personnel in the military healthcare system. How the degree-granting capability is accomplished and integrated into the education process will drive the accreditation requirements the METC must meet. It is common practice among existing accrediting bodies to specify certain organizational entities, faculty requirements, and a senior advisory body, such as a board of governors outside the organization, as requirements for accreditation. Actual requirements will vary, depending on whether METC is a stand-alone degree granting institution or acts in partnership with another organization, and will drive some components of the METC structure. Efforts to affiliate with existing degree granting institutions are described in Paragraph d below.

c. Command Structure. The structure of the command element in the METC will, of necessity, include components focused on three major areas. The first is support functions that enable mission accomplishment of the other components of the organization. The METC will be a division or wing-sized organization of between 12,000 and 13,000 individuals at any given time. The full range of functions normally associated with the command and personal staffs of the commander will be essential to supporting METC operations. The staffs would function under the guidance and supervision of the organization's Chief of Staff. The METC is expected to have an ADSL of approximately 9,000 at any given time. Student management and caring for the welfare of that number of students will be a primary area of focus and is the second area to which a component of the organizational structure will be dedicated. The final focus is education and training. This will be the primary mission of the organization and will likely contain the preponderance of the resources in the organizational structure. A potential model for the structure is discussed later in this paper as a start point for organizational design.

d. Degree Granting Institution. The METC will be the primary medical education and training organization in the DOD with the mission to be the world class center for medical basic and specialty training, capitalizing on the synergy of co-locating and integrating similar service specific training to build enhanced interoperability and deployability among personnel of the Service medical departments.

(1) As the primary medical education and training organization for the DOD, the METC will be responsible for lifelong learning throughout the careers of its military and civilian personnel. In addition to the requirements for BRAC, this mission is specifically stated in TO-5. To provide for educational progression and continual sustainment training, the METC will pursue the capability to grant degrees either as an internal capability or in partnership/association with other degree granting institutions. A best value decision, with economic analysis as a primary component, will drive the final outcome on how the METC will go about gaining this capability. It is worthy of note that the Air Force has specifically stated that the ability to continue to grant degrees to its personnel is a primary recruiting and retention tool; keeping the ability to grant degrees is a "line in the sand" that it will not cross.

(2) As noted in Paragraph 5, b, (2) above, status as a degree granting institution may dictate that the METC incorporate certain governance capacities into its organizational structure. While the details will vary based on related affiliations and the agency granting status, likely requirements will include a board of governors, competent registrar and student management capabilities, and a strong academic component. At present the single degree granting medical institution in DOD is the Uniformed Services University of Health Sciences (USUHS). Study of the organizational structure, charter, and

resourcing of USUHS is ongoing and may provide key information related to structuring the METC to meet the requirements for granting degrees either directly or through affiliation.

(3) Designation of the METC as a degree granting institution will require that it be an accredited educational institution. Again, while the accreditation requirements may vary among accrediting bodies, we can expect that certain structural components will be required in the organization. The Services must come to agreement on the accrediting body and on the policies required to meet accreditation standards.

(4) The ability to grant recognized college level credits and appropriate degrees will be dependent on a number of other factors. Two of the primary factors are:

(a) Faculty qualification. In order for the METC to become a degree granting organization or partner with other facilities to do so, the faculty will need to meet strict academic qualifications. The Air Force and Navy are ahead of the Army in this regard as most Navy instructors independently obtain associate degrees while Air Force requires that instructors in their training institutions have an associate's degree as a minimum.

(b) Strategic Studies. Designation as a degree granting institution or partnership with another degree granting entity will drive a strategic studies capability in the METC, to include a governed, integrated research capacity as a component of the organization. The focus will likely be on operational research using both lessons learned from the contemporary operating environment (COE) and concept development to build military medical capability for future operations.

(5) As an initial set in meeting the degree granting requirements of the METC, the FOSC has forwarded a letter requesting METC affiliation with the Community College of the Air Force (CCAF). If approved the METC would be the first non Air Force organization affiliated with CCAF. As an affiliate the METC would be required to meet all accreditation requirements. The result would be that Air Force personnel could be granted credit and degrees under the auspices of the CCAF as they are now and personnel from the other Services could receive course credits that are transferable to other educational institutions as a component of achieving degree status. While several options for granting degrees to non Air Force personnel are under consideration, the details are yet to be defined.

e. Instructional Requirements. Instructional requirements will drive the organizational structure for academics with a resultant impact on the overall organizational structure. The METC must take advantage of every opportunity to develop and present joint education and training while maintaining the capability to meet service-specific training requirements.

(1) The instructional requirements analysis process will include a scope of practice review and critical task analysis. Given the limited timeframe for BRAC implementation, however, the review process is likely to be somewhat different than the traditional process and will contain all the elements of a complete review but may be run in parallel rather than sequentially. Because requirements drive education and training, the analysis will consist of a detailed doctrine and mission driven review of medical specialty training needs across the Services to identify critical tasks that are common or service-unique. These tasks are driven by operational requirements in field, fleet, and fixed activities; student career development; and lifelong learning requirements. Service subject matter experts (SMEs) will review the critical task lists to determine where consolidation is possible and where service-unique curriculum is needed.

Senior SMEs will review the lists of tasks identified as non common to identify those that are:

- Not critical
- Critical but should be common
- Critical but not common
- Critical and not common but should be trained as a benefit to the student if course resourcing permits
- Critical and not common, should be trained as a benefit to the student, and can be trained if the methodology is modified to meet course resource availability
- Tasks upon which no agreement can be reached

Tasks for which no agreement has been reached will be presented for resolution to an objective tri-service review team which will have authority to approve the outcomes of the ITRO driven effort. This team of objective reviewers will have approval authority within parameters yet to be determined. Those issues on which agreement is not achieved through the review process will go for decision to the Flag Officer Steering Committee (FOSC) consisting of flag officers representing the medical training capabilities of the Services. The FOSC decisions complete the review cycle. From this process the education and training courses will be developed. Common tasks will form the basis for joint training; non common tasks will constitute service-specific training. Figure 1 graphically demonstrates the process.

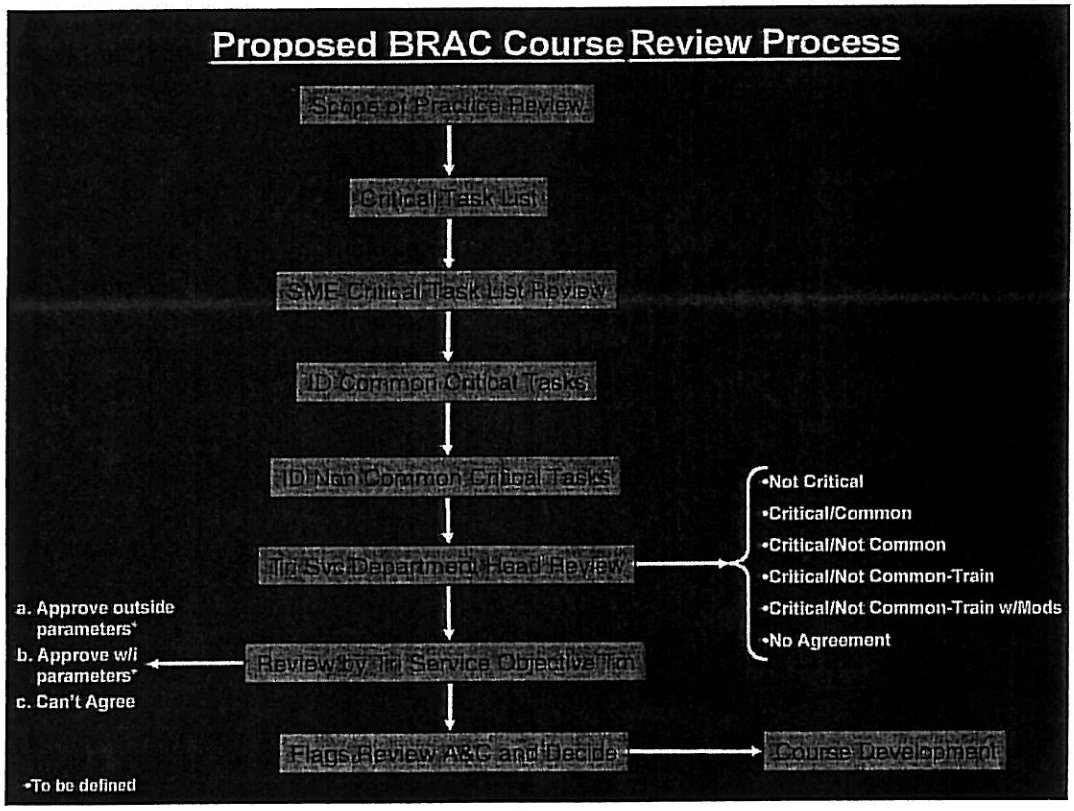


Figure 1

(2) Execution of education and training needed to meet requirements developed in the ITRO analysis can only be enabled by a process that captures and optimizes opportunities for training jointly yet specifically accounts for service-specific training requirements. Figure 2 shows a basic concept for execution of education and training in the METC.

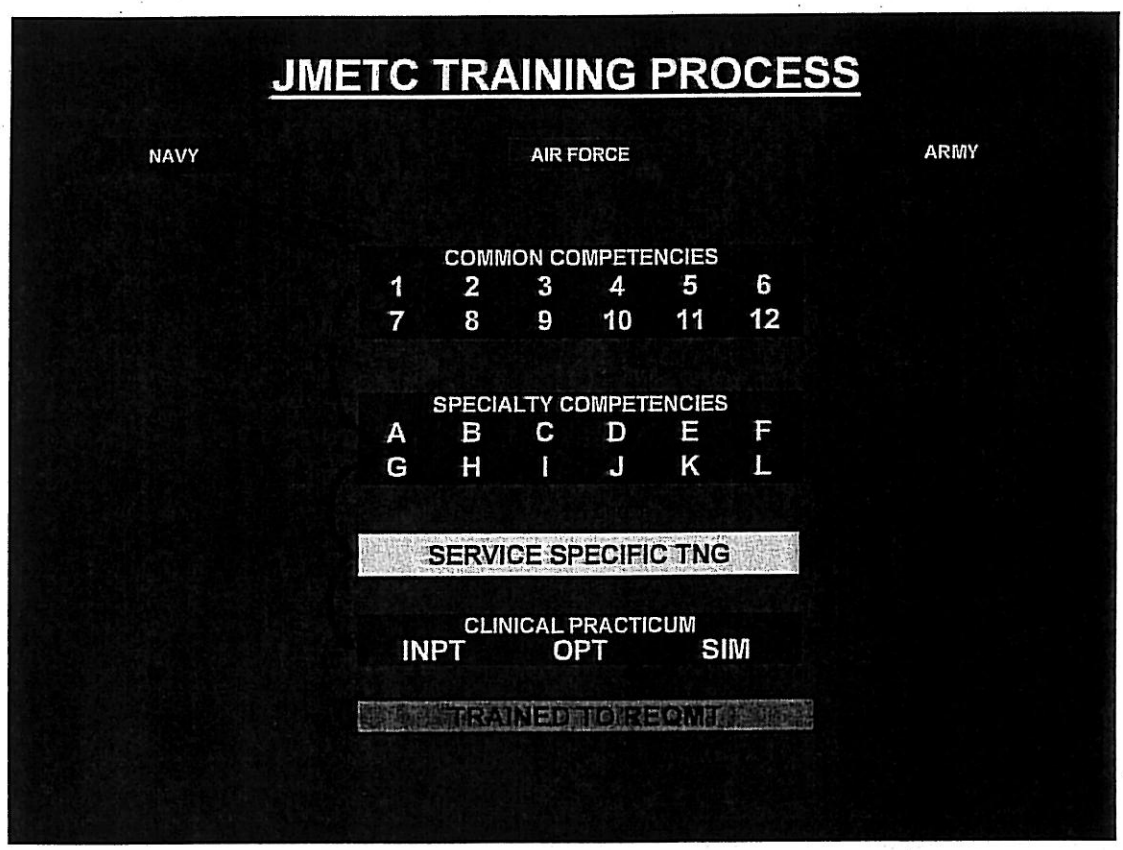


Figure 2

(a) In Figure 2 "common competencies" represent competencies based on the critical tasks identified in the ITRO process that are common to more than one specialty, for example anatomy and physiology which applies across numerous specialties. (NOTE: In this discussion the term "specialty" refers to a given capability of medical personnel and may refer to officer or enlisted capabilities, e.g., laboratory technician or medical logistics officer.) The "specialty competencies" represent competencies from tasks that are common across the Services but are specific to a given specialty, for example radiation physics for radiology specialists.

(b) In the Phase I portion of the process students from different Services would train together. For the common competencies even students from different specialties may also train together where it makes sense to achieve efficiencies and produces the best student outcome. Phase II of the process accounts for the service-specific requirements. Phase III is the clinical practicum which is a component of the majority of medical specialties. It may consist of practical experience containing inpatient, outpatient, and/or simulated patient contacts.

(c) The outcome of the training will be world class medical personnel, trained to requirements that are doctrine and mission driven. In a perfect world the ITRO review process would identify requirements that are the same across all the Services for a given specialty. For example, if Figure 2 were representative of the training requirements for radiology technicians the critical tasks

identified might be as presented in the Navy portion of the graphic. In that event, qualification as a radiology technician would require common competencies 1, 3, 5, and 7 as well as specialty competencies A, C, and E and no service specific training. It is unlikely, however, that the ITRO review will produce critical task lists that drive the exact same competency requirements for a given specialty in all Services. This model accommodates the training requirements in either case.

(d) Regardless of the instructional model adopted, numerous issues pertaining to management of the academic process will remain. Specific questions will include but not be limited to:

- What will be the requirements for curriculum update since this action is a major resource driver?
- What is the process and system to be used for developing and documenting programs of instruction (POI)?
- How will the METC provide technical training controls? Will they be joint and/or service-specific? How will the requirements for the clinical practicum be controlled?
- Will student evaluation plans (SEP) be consolidated or service unique?
- What is the process for operational training inspections? Will this process be service specific or a unified IG team?

f. Student Management. Student management for an ADSL of 9,000 will be a constant challenge. The organizational structure of the METC must address questions and student issues that are both joint and service-specific in nature including but not limited to:

- Will student management be central or service run?
- How will the registrar functions interface with the student management component of the organization to meet training documentation requirements?
- How will the METC meet personnel management and other service-specific requirements, e.g., academic/fitness/efficiency reports?
- What will be the conflict resolution process? What will be the student load planning process that drives resource requirements?
- How will disciplinary actions be managed?
- How will service specific military training be managed?

g. Resource Flow. The METC academic and student management processes will drive resource requirements for the organization. Actual resource authorization, allocation, and flow will depend on the command environment in which the organization operates. Questions about funds source and flow; budget planning and execution; manpower documentation, authorization, and assignment; logistics management; and control/management of facilities are still to be addressed. Decision on the command environment will clarify but not necessarily resolve some of the issues and questions such as "What are ground rules for interaction with the installation?" and "What are the potential impacts of BRAC-derived installation interactions for the METC?" will remain. Early resolution of resource issues is essential to successfully transition to a functioning METC. It is important to note that there is an additional level of complexity in managing funds for medical training because they do not all come from the same source as stated above in Paragraph 3, c, (3) above reference Air Force funding for medical training.

h. Enterprise Infrastructure. The electronic systems infrastructure to support education and training as well as support processes is an issue that is beginning to be addressed but it looms large in the METC's future. The METC may be sufficiently large and complex to warrant its own information management (IM) structure. Decisions regarding whether the infrastructure will be service-specific or whether the METC will develop a true enterprise infrastructure will be the driver for that component of the organizational design. Recent Navy successes with the integrated learning environment are likely to drive a best practice selection for course delivery resulting in additional electronic infrastructure requirements and increased justification for a separate IM capability.

6. Possible Model. The model chosen to serve as a baseline for development of the METC organizational structure must take into account all of the issues detailed in Paragraph 5 above. Additionally it must address certain basic military and management practices such as span of control, relationship to the Service lines, and interface with the host installation. The fact that there will be service-specific training requirements dictates service-specific components in the organization. The possibilities for meeting this full range of requirements in a "university" setting can vary from a single activity such as a college of health sciences to multiple colleges addressing different foci. Figure 3 is not a detailed model but can serve as a concept baseline for development of the organizational structure of the METC.

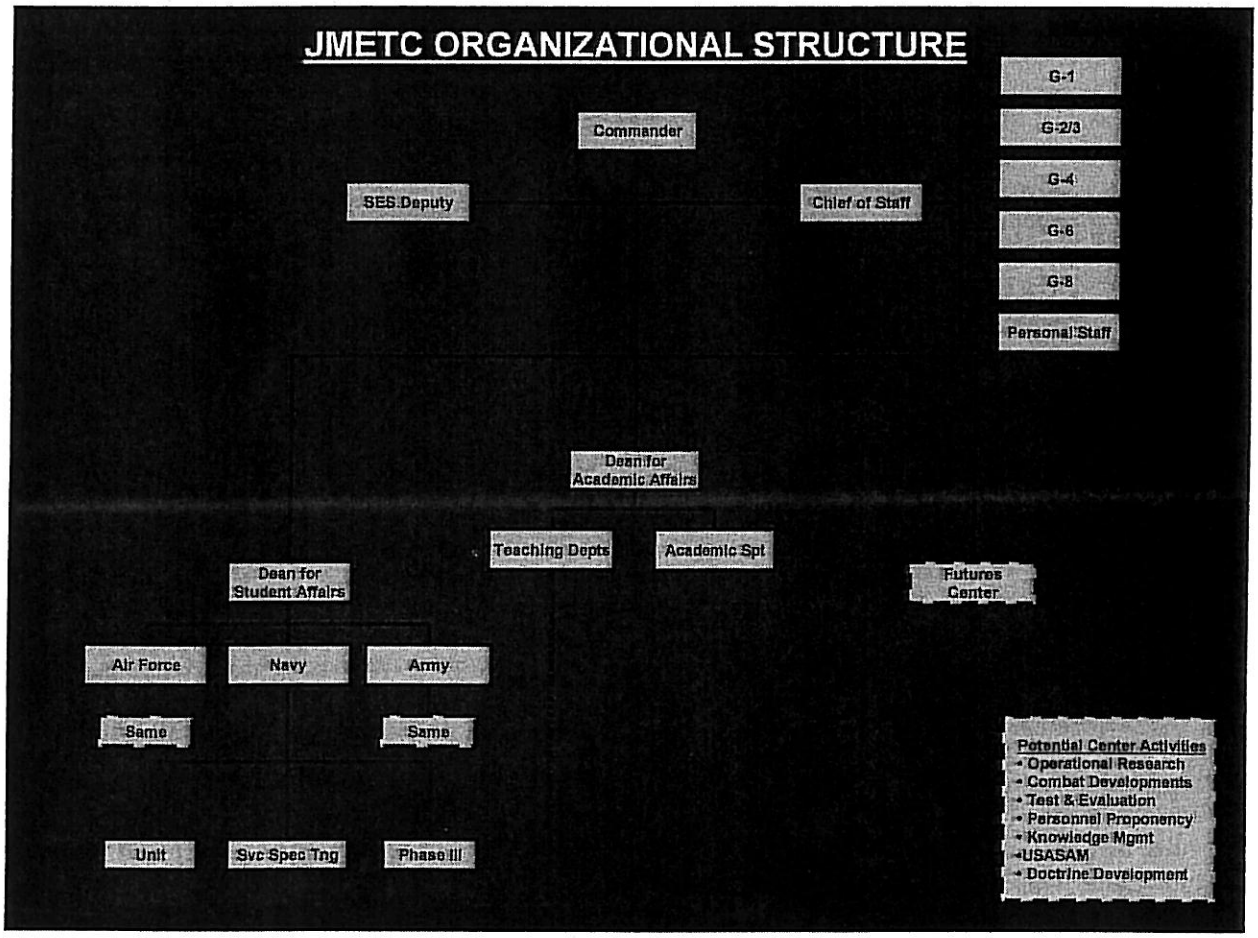


Figure 3

a. The proposed structure shown in Figure 3 focuses on the three major elements outlined in Paragraph 5c above. It accounts for student management, academics, and the support functions required to execute both. In addition, the structure provides for a "futures activity" which can house a myriad of ancillary activities associated with education and training to include, in this case, operational research. This "futures activity" will form the baseline for development of a strategic studies entity for the METC.

b. The position of Dean for Student Affairs would be a command position in a direct line from the Center commander and would be supported by subordinate service-specific commands. As a result, the structure accounts for the requirement to have service-specific capability present in the organization by providing command and control and oversight of service-specific training requirements.

c. The Dean for Academic Affairs is responsible for management of the teaching departments in the METC. As such this individual is responsible for execution of the education and training driven by the critical task lists resulting from the initial ITRO reviews. The academic dean position might also have a command relationship to the Center commander supported by the requirement to provide command and control for the faculty and staff of the teaching departments. Command and control for the METC headquarters staff could be accomplished via attachment to one or the other of the subordinate command elements or via a separate headquarters detachment.

d. The organizational structure in Figure 3 is flexible in that it can accommodate the full range of potential command environments. If the METC were to be designated as a true joint organization the support staff could easily morph from a G-staff to a J-staff. It is also capable of accommodating a unified organization, executive agency, or any of a series of hybrid organizations.

e. The design also provides for teaching department input to the service-specific and clinical practicum components of the training. The cooperative effort between teaching departments and the service-specific command elements will insure the training provided addresses the critical tasks that lead to achieving excellence in the required medical competencies. It will also insure that accreditation standards are met.

7. Transition. Transition from present state to full operation of the METC is a pathway that is both challenging and complex. It is essential to establish and provide the requisite authority to an entity responsible for planning and execution of the transition. In addition, that entity must be resourced sufficiently to set it up for success. Currently, planning is being executed by the METC Executive IPT, with representation from all of the Service medical departments. The team has developed a series of integrated process teams (IPTs) to address the issues presented in this paper and to anticipate and address other issues as they arise. The proposed structure (Enclosure 1) received approval from the FOSC at a meeting on 9 February 2006. The IPT membership is beginning to address issues associated with formation of the METC.

a. Transition Team. A number of previously identified transition issues have been addressed and resolved by the FOSC, specifically as they pertain to management of the transition process.

- Will the current METC Executive IPT form the nucleus of the team to plan and manage movement from current to end state? The METC Executive IPT, under the guidance and supervision of the FOSC, will be the primary integrator of the transition process.

- What is the role and authority level of the Executive IPT? Will it be chartered? The Executive IPT will be the oversight and decision making focal point for the transition and for the overall IPT structure. The Executive IPT charter should be in place NLT the end of March 2006.

- Will input to the transition process from outside entities be cycled through the Executive IPT to insure integration of activities toward a common goal and to achieve optimum efficiencies? The Executive IPT will be for focal point of input to the METC transition process.

- What will be the conflict resolution process for transition issues? The METC Executive IPT will be the primary conflict resolution body. Issues that cannot be settled in that forum will go the FOSC for decision.

b. Synchronization. This effort represents consolidation of training for more than 100 specialties from multiple locations to Fort Sam Houston. Synchronization of movement is potentially the most significant challenge in the consolidation process.

(1) The move requires significant construction of both educational and life support facilities, all of which must be synchronized to match availability of education facilities with the courses being moved. At the same time, the life support facilities, i.e., dormitories, dining facilities, chapels, gymnasiums, and so on, must be available in the quantity and location needed to support the student population. That in itself is a significant challenge, particularly given the vagaries of construction timing. Additionally, it is quite possible that the educational facilities may be funded from one source and life support from another. This will add significantly to the challenges associated with synchronizing the occupancy dates of both types of facilities.

(2) Facilities, however, are not the only synchronization issue. Development of the METC as an entity must be synchronized with the movement of courses. In every case the command and control, staffing, and processes, as well as the facilities, must be in place to receive the staff, faculty, and students associated with the courses as they move. A valid analogy is the building and commissioning of a new ship in the Navy. At some point in the process and before construction of the ship is complete, the Navy assigns the commanding officer and, over time as the construction proceeds, other leaders and crew to insure that the vessel is properly completed and is prepared to complete its mission once end state is achieved. On 12 October 2005 the FOSC approved this model for establishing the METC, understanding that it will mean running some things in parallel with existing activities.

(3) Synchronization of course movement is also key to maintaining the numbers of students to meet force structure requirements. Of all the components of the synchronization issue, this facet is the most important and will drive execution of all others.

c. Command Transition. Movement from the current command structure spread across three Services to the METC structure presents several significant challenges that require recognition early in the process.

(1) Training is a Service line responsibility. Formation of a joint training capability will not change that fact. It is critical that the METC have a built in process to continually pulse Service line requirements and insure the education and training provided to students is meeting the needs of combatant and fixed facility commanders.

(2) Transition of command will require a number of interim steps because training organizations will not move as a single entity. Courses will move in phases over time and existing training organizations will run in parallel with the METC for some period even though they are executing different courses. It is essential to develop functional interim models/steps for those institutions to transition them from current structure to end state.

(3) In the case of the Air Force, medical training is part of a Service-level line training command, AETC, rather than a medical command as in the other two Services. Early determination of the relationship between AETC and the METC will facilitate development of METC organizational structure and processes.

8. Ancillary Issues. Several other issues will impact on the structure and function of the METC.

a. Center Functions. The proposed baseline organizational structure shows a futures cell/strategic studies capability as a potential component of the METC. Part of the driving force for the futures cell is the question of how to align the functions from the Center components of the AMEDDC&S when the METC is formed. While some current Center functions have parallels in the other Services, no determination has yet been made on what components might appropriately be considered for consolidation. The strategic studies cell is an appropriate location for joint activities such as operational research but what is the appropriate structure for activities that are service-specific? Do they belong in the METC at all?

b. Future Potential.

(1) The BRAC announcement in May 2005 specifies alignment of enlisted training together but it is clear from contact with the Medical Joint Cross Service Group (MJCSG) that the intent was that officer training be included where it makes economic or functional sense to do so. Some consolidation of officer and medical readiness training is included in the METC planning; flexibility to accept additional officer training requirements will be included in the end state. TO-5 has greatly increased the potential for integration of officer, leadership, and lifelong other training in this process. Paragraph 10 below contains additional information on TO-5.

(2) Other education and training capabilities may find it advantageous to be affiliated with or become components of the METC. Potential activities include portions of the Fleet Marine Force medic training currently conducted under the Marine Corps Training and Education Command (TECOM), graduate medical education (GME), the Defense Medical Readiness Training Institute (DMRTI), and others. The issue is that the METC structure must possess the flexibility to include other training activities should such actions make functional and/or economic sense.

c. Specialty Accrediting Body Affiliations. There is impetus among the Services to pursue and maintain affiliation with national and/or international accrediting bodies for allied health specialties. To achieve this affiliation for students in these specialties, required standards would be incorporated as the minimum requirements for didactic and clinical components of the curriculum.

d. Flag Officer Positions. As noted earlier, the METC will be a division or wing-sized organization. Historically, Army divisions have had three flag officer positions, the commanding general and the deputy commanding generals for maneuver and support. Designation of flag officer positions in the METC and the propensity of the Services to fill those positions may have an impact on the level of success achieved by the organization. The positive presence of Service flag officers will help to guide and set the tone for joint training efforts. The graphic in Figure 3 does include a Senior Executive Service (SES) position as a deputy to the commander. The intent of this position is to meet the need for interface, coordination, and management necessary to insure support to the METC, as the largest resource consumer on the installation, is properly coordinated and prioritized. On an installation with multiple major headquarters headed by flag level officers, an SES position will be required to do so.

9. Decision Points. Given the number and magnitude of the issues in transitioning from the current status to an end state METC, it is evident that significant flag officer influence will be required to set the stage for and achieve success. Following are a number of issues for which the current METC Executive IPT has identified the need for flag officer support. Status of responses to the original white paper questions are shown in parentheses.

a. Early guidance on and support for the process to reach decision on the command environment in which the METC will operate. (This question has been overcome by the Joint/Unified Medical Command Study. It may apply again if the summer '06 decision at DOD does not establish some form of a joint or unified medical command.

b. Early guidance on and support for the process to reach decision on senior command lines for the METC. (Same as above.)

c. A charter for the METC Executive IPT that

- Designates composition and structure
- Defines roles, responsibilities, and authority levels to include how/if outside agencies will be included in the transition process. A process is needed to insure integration of all efforts and that activities are guided toward common goals and efficiencies.
- Approves the IPT process and recommended IPT structure for the transition process. The FOSC approved the latest iteration of the IPT structure on 9 February 2006. The charter is being modified to include requirements from TO-5 for which the FOSC has responsibility.

d. Agreement to pursue status for the METC as an institution capable of granting degrees (Agreed by the FOSC, 12 Oct 05).

e. Approval of the ITRO Course Review model (Approved by the FOSC; 12 Oct 05).

g. Approval of the METC education process outlined in Figure 2 above as a baseline for developing the METC education model (Approved by the FOSC, 12 Oct 05).

h. Approval of the METC model outlined in Figure 3 above as a baseline for developing the METC organizational structure (Approved by the FOSC, 12 Oct 05).

i. A positive, in-person statement to the Service educational leadership expressing support for the transition process and establishing the expectation of support from those leaders. (FOSC members have made it clear to members of their organizations on multiple occasions and in multiple forums that this is an important transition for military medicine and that wholehearted participation by all stakeholders is key to its success.)

j. Guidance on conflict resolution during the transition process (Approved by the FOSC 12 October 2005):

- Designation of the METC Executive IPT as the primary conflict resolution entity
- Identification of the FOSC as the conflict resolution body for issues that cannot be solved at the Transition Team level
- Support to carry issues to the advisory level above the FOSC as required for information or resolution

k. Agreement for quarterly FOSC meetings as a minimum to guide the transition process. (Approved by the FOSC 12 October 2005; modified to provide for quarterly in-person meetings three times per year with VTCs in each month where there is no face-to-fact meeting of the FOSC.)

10. Roadmap Initiative # 5. The MHS Roadmap Initiative # 5, *Joint Medical Education and Training Focused on Performance-Based Management*, adds education and training language contained in the Quadrennial Defense Review (QDR) to the mission of the FOSC by making it the Office of Primary Responsibility for planning and execution of the initiative. TO-5 addresses increased joint leadership training at levels throughout the grade structure to keep medical leaders current in the ever changing deployed and TRICARE environments we know now and anticipate in the future.

a. The METC is the ideal organization to address this initiative and will be capable of integrating leadership training with all levels of professional/technical education and training. In addition, the FOSC has already established a planning infrastructure, the METC IPT structure, capable of addressing many of the issues detailed in TO-5. Only three new IPTs, Leadership, Joint Staff Officer Development, and Lifelong Learning, had to be added to the existing METC IPT structure to address the issues detailed in TO-5. The METC must maintain the flexibility to include joint leadership training in its course structure as well as to take advantage of joint training for medical leaders sponsored by other organizations such as Joint Forces Command (JFCOM).

b. The tasks specifically addressed in TO-5 include:

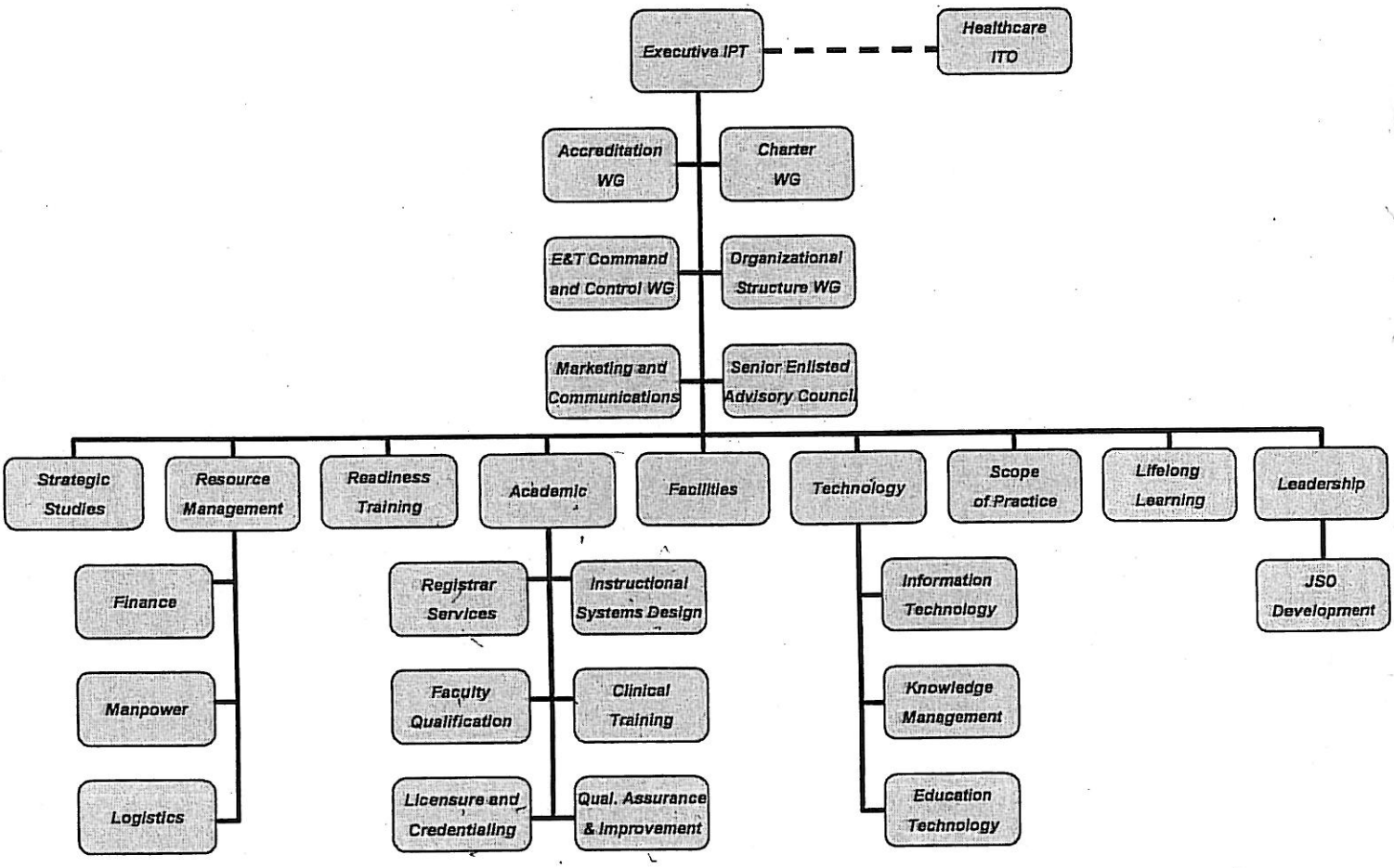
- Identify training commonalities
- Develop core curriculum
- Identify best practices
- Develop Joint and Service-specific lifelong learning modules
- Performance-based leader training
- Leverage and enhance current joint leader training

c. TO-5 integrates BRAC and transformation initiatives, specifically in the first three bullets of Paragraph b above but significantly expands the scope by including officer, enlisted, and civilian education and training where the BRAC language focused on enlisted training. On 15 February 2006 the FOSC forwarded to the MHS-OT a Milestone 0 document laying out a basic implementation plan timeline and associated resource requirements for TO-5. Planning to integrate related tasks continues but, because TO-5 greatly expands METC Executive IPT planning/coordination requirements and available resources are already committed to BRAC planning and execution, action on TO-5 will be limited pending receipt of additional resources.

11. Summary. Establishing a Medical Education and Training Center for military medicine is a complex undertaking made more complex by the addition of requirements from TO-5. These actions will require focused effort on the parts of all the Service Medical Departments. Essential elements that must be addressed include the command climate; governance and accreditation; degree granting capability;

achieving efficiencies in the education process while providing quality education that develops world class medical personnel; building the right organizational structure; close Service, Joint staff and COCOM cooperation in addressing TO-5; and continual efforts improve course content and process via a permanent version of the ITRO review. Flag officer guidance and support will be essential elements of success throughout the transition. Achieving the end state of a world class institution, constantly striving for excellence in joint medical education and training that provides the best trained medical personnel to combatant and fixed facility commanders and to the Soldiers, Sailors, Airmen, and Marines who are its ultimate customers will make every ounce of effort and every resource expended worthwhile.

Transition IPT Structure



Enclosure 1